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No. 94-1109

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1994

DEL CRANE MEDICAL CORPORATION,

Petitioner,

vs.

DEPARTMENT OF HEALTH SERVICES,
AN AGENCY OF THE STATE OF CALIFORNIA

Respondent.

On Petition For Writ Of Certiorari To The Court Of Appeal, Third Appellate District, State Of California

BRIEF OF RESPONDENT, DEPARTMENT OF HEALTH SERVICES, IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

DANIEL E. LUNGREN
Attorney General of the
State of California

CHARLTON HOLLAND
Assistant Attorney General

DENNIS ECKHART
Supervising Deputy Attorney
General

*RAOUL THORBOURNE
Deputy Attorney General
(CA Bar No. 72932)
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone (916) 324-2884

Attorneys for Respondent

*Counsel of Record

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QUESTIONS PRESENTED

1. Whether this Court is without jurisdiction to hear the two questions presented for resolution by petitioner (Petition, p. i) since these questions were not raised and/or were not decided below.

2. Whether, under the federal Medicaid system, the State of California may establish minimum standards and qualifications for providers of services to program beneficiaries.

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STATUTORY AND CONSTITUTIONAL PROVISIONS

42 United States Code section 1396a(a)(22) ("A State plan for medical assistance must . . . include descriptions of . . . (D) other standards and methods that the State will use to assure that . . . services provided to recipients of medical assistance are of high quality. . . . ");

42 United States Code section 1396a(a)(30)(A) ("A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and payment for, care and services available under the

plan . . . to assure that payments are consistent with efficiency, economy, and quality of care. . . . ")

SUPPLEMENTAL STATEMENT OF THE CASE

A. BACKGROUND:

Pursuant to Rule 15.1, the Department of Health Services (hereinafter "the department") supplements Del Crane's statement of the case to point out omissions and inaccuracies.

Initially, it is noted that, contrary to petitioner's contention, this case is *not* about any attempts by the State of California to refuse to reimburse petitioner as provided by federal law. (Petition, pp. 6-10.) The sole issue in this case, and the sole issue decided below, was whether the department could lawfully de-activate petitioner's Medi-Cal[1] provider number given the undisputed fact that petitioner failed and refused to comply with the Medi-Cal operational and disclosure requirements for providers of incontinence supplies contained in California Welfare and Institutions Code sections 14125 et seq. (Appendix A hereto.) The decision below did not reach the reimbursement issue petitioner raises herein since no purpose would have been served in deciding the correct amount

[1] In this brief references to "Medi-Cal" are to the Medicaid Program in California and references to Medicaid are references to the Medicaid Program in general as applicable to other states or to the federal laws and regulations which apply. Unless otherwise noted, any reference to Medicaid is fully applicable to Medi-Cal.

petitioner may be owed if the latter is lawfully barred from participating in the Medi-Cal program as a provider in the first place.

The trial court denied Del Crane's petition for Writ of Mandate to reinstate its Medi-Cal provider number, ruling that petitioner had not demonstrated that the department's rescission of its provider number, on the basis of Del Crane's refusal to comply with the state's regulations, violated any state or federal law or regulation. The California Court of Appeal affirmed. (Petition, Appendix B.)

In upholding the trial court's judgment, the Court of Appeal declined to reach petitioner's constitutional challenge to one of the operational requirements set forth in Welfare and Institutions Code section 14125, namely, that providers of incontinence supplies maintain an office or business location in California. The Court of Appeal concluded that petitioner had failed to show good cause for waiting until its reply brief in that court to raise for the first time the Commerce Clause argument regarding this requirement, and added that consideration of that issue was particularly inappropriate in this case because critical factual questions remained to be adjudicated. (Petition, Appendix B, p. 15a.) And, given its agreement with the trial court that the department was authorized to deactivate petitioner's provider number because of petitioner's refusal to comply with any of the relevant Medi-Cal regulations, the Court of Appeal did not reach the Medicare reimbursement issues either.

The California Supreme Court summarily denied review, also without reaching either the Commerce

Clause or the Medicare reimbursement issues petitioner raises herein. (Petition, Appendix A.)

B. FACTS:

This case involves California's administration of the Medi-Cal program with respect to providers of incontinence medical supplies. In this context, incontinence medical supplies include disposable medical supplies such as diapers, absorbent pads, and the like. The California Legislature has devoted a considerable amount of attention to providers of incontinence medical supplies. Special rules apply to participation by these providers.

Effective July 31, 1990, the Legislature substantially amended the Medi-Cal program in the area of participation by providers of incontinence medical supplies. Sections 14125 and 14125.1 through 14125.9 were added to the California Welfare and Institutions Code to stringently regulate this class of providers. (Appendix A.) Additional provisions were added, effective January 1, 1992, which further strengthened regulation of these providers. (See Appendix A, § 14125.2.)

Subdivision (b) of section 14125.2 requires all Medi-Cal providers of incontinence supplies to establish a place of business in California which is readily identifiable as a medical supply business, that the place be open to the public at regularly established business hours, have incontinence supplies in stock or immediately available, and meet all local laws and ordinances regarding business licenses and operations. Additionally, as a condition of continued participation in the Medi-Cal program, business entities providing incontinence medical

supplies would henceforth have to provide the department with the name of the corporation, the official titles of all applicants, and a list of all the corporate officers as well as the California driver's license or California identification card number of all applicants, co-owners, corporate officers and financially interested parties. Providers would also henceforth be required to provide to the department their California business permit control number issued by the State Board of Equalization for the business location from which they rendered services to the public, a statement of all sources of capital, identity of all investors, disclosure of all manufacturers, suppliers and providers doing business with the provider, and disclosure of all entities to whom the provider has extended a line of credit. Welf. & Inst. Code § 14125.8, subds. (a)(1) through (5); Petition, Appendix B, p. 6a.

Because of these new operational and disclosure requirements, all provider numbers for suppliers of durable medical equipment, a category which includes incontinence supplies, were deactivated pending receipt of the newly-required information. Re-enrollment of out-of-state providers, such as petitioner, was permitted only for the provision of supplies on an emergency basis when Medi-Cal beneficiaries were traveling in the provider's home state. (Petition, Appendix B, p. 7a.)

The reasons for these changes are evident from the implementing legislation. In enacting this legislation, the Legislature was attempting to curtail fraud and to reduce the excessive fees that some providers, particularly out-of-state providers, had been charging for these items. (Petition, Appendix B, pp. 5a-6a.)

Following the enactment of the 1990 legislation and the deactivation of the Medi-Cal provider numbers, the department mailed out packets to all providers advising them of the new operational and reporting requirements. The packet included application forms which the providers were required to satisfactorily complete and return to the department before their provider numbers could be re-activated.

In addition to the aforementioned packet, the department also notified out-of-state providers, including petitioner, that Medi-Cal would henceforth reimburse them only for emergency services provided to Medi-Cal beneficiaries traveling in the provider's home state.

C. PETITIONER'S RESPONSE TO THE 1990 LEGISLATION:

The department temporarily deactivated petitioner's number on May 18, 1990, even before the effective date of the 1990 legislation, because the amount of Medi-Cal payments made to petitioner in the preceding year appeared excessive for an out-of-state provider and raised concerns within the department. Although the department later reinstated petitioner's number, on July 26, 1991, petitioner's provider number was deactivated again, retroactive to June 1, 1990, when an audit revealed that the over $327,000.00 the department had paid petitioner during the preceding year represented reimbursement for incontinence supplies to Medi-Cal beneficiaries

who were residents of long-term care facilities located in California. These payments were clearly inconsistent with the 1990 legislation which limited Medi-Cal reimbursement for out-of-state incontinence suppliers to situations when California beneficiaries were travelling in the provider's home state. Additionally, these payments to petitioner were improper because effective January 1, 1991, the newly calculated per capita reimbursement rate for these beneficiaries included an augmentation for various items, including incontinence supplies. Accordingly, providers, such as petitioner, could no longer separately bill Medi-Cal for incontinence supplies. Significantly, petitioner does not dispute any of the foregoing facts. (Petition, Appendix B, pp. 6a-7a.)

For these reasons, and because petitioner has since steadfastly refused to comply with any of the new operational and reporting requirements contained in section 14125, i.e., it did not establish a business location in California and failed to complete and return the re-enrollment packet requesting the newly-required information, its provider number remains deactivated. (Petition, Appendix B, p. 7a.)

SUMMARY OF ARGUMENT

This Court is without jurisdiction to hear either of the questions petitioner raises in this appeal. First, petitioner waived its right to have this Court rule on the Commerce Clause issue by failing to timely raise it below. Second, although petitioner did properly raise the Medicare Part

B reimbursement issue before the state courts, the California Court of Appeal based its decision on other grounds and expressly declined to reach the reimbursement issue. In the absence of a final state judgment or ruling on either of these issues, this Court should deny the petition for failure to comply with the requirements of Supreme Court Rule 14.1(h).[2]

The decision below actually concerned the authority of the California Department of Health Services to establish and enforce minimum qualifications for entities wishing to provide services to Medi-Cal program beneficiaries. In this regard, it is well established that under the Medicaid system states are not only authorized, but they are in fact *required* to establish minimum qualifications for providers of services under the program in order to insure that patient care standards are maintained. 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A); *Schweiker v. Hogan*, 457 U.S. 569,

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[2] Rule 14.1(h) provides in pertinent part that:
"(h) If review of a judgment of a state court is sought, the statement of the case shall also specify the stage in the proceedings, both in the court of first instance and in the appellate courts, at which the federal questions sought to be reviewed were raised; the method or manner of raising them and the way in which they were passed upon by those courts; and such pertinent quotation of specific portions of the record or summary thereof, with specific reference to the places in the record where the matter appears (*e.g.*, ruling on exception, portion of court's charge and exception thereto, assignment of errors) as will show that the federal question was timely and properly raised so as to give this Court jurisdiction to review the judgment on a writ of certiorari. . . . "

589-591 (1982); *Harris v. McRae*, 448 U.S. 297, 301 (1980). Therefore, as a provider of incontinence supplies to Medi-Cal beneficiaries, petitioner is required to comply with the state's regulations regarding the minimum qualifications for such providers. Petitioner's undisputed refusal to so comply authorized the department to deactivate its Medi-Cal provider number. The decision below rejecting petitioner's contention that it is not subject to California's regulatory authority, (notwithstanding the fact it seeks Medi-Cal reimbursement for services provided to Medi-Cal beneficiaries), was therefore proper and should remain undisturbed.

ARGUMENT

I.

THE PETITION SHOULD BE DENIED INASMUCH AS THERE IS NO FINAL STATE COURT JUDGMENT OR RULING REGARDING EITHER OF THE QUESTIONS PETITIONER PRESENTS FOR RESOLUTION HEREIN

This Court has jurisdiction to hear appeals from state court judgments only when a federal question is involved. 28 U.S.C. § 1257 subdivision (a). However, before this Court may entertain such an appeal, Supreme Court Rule 14.1(h) requires the petitioner to state:

> " . . . the stage in the proceedings, both in the court of first instance and in the appellate courts, at which the federal questions sought to be reviewed were raised; the method or manner of raising them *and the way in which they were passed upon by those courts*. . . . " (Emphasis added.)

In interpreting these requirements, this Court has held that petitioners have the burden of establishing that the federal question was timely and properly raised in the state court proceeding. *Godchaux Co. v. Estopinal*, 251 U.S. 179, 181 (1919); *Beck v. Washington*, 369 U.S. 541, 550-554 (1962). A failure to observe state procedural rules for the raising of constitutional questions requires dismissal of the petition. *In re Lamkin*, 355 U.S. 59 (1957). Finally, this Court has also held that the federal claim must have both been raised *and decided* by the state court. *Whitney v. California*, 274 U.S. 357, 360 (1927). Thus, this Court has declined to exercise jurisdiction in situations where the highest state court expressly refuses to decide the federal question because of petitioner's failure to comply with the state procedural requirements for raising such questions. *Pennsylvania R. Co. v. Illinois Brick Co.*, 297 U.S. 447, 462-463 (1936).

In the instant case, it is undisputed that petitioner did not raise the Commerce Clause issue regarding the in-state office requirement before the trial court. In fact, petitioner did not even raise the issue in its opening brief to the California Court of Appeal. Not until the filing of its reply brief with that court did the Commerce Clause issue first surface. In these circumstances, the California Court of Appeal specifically, and properly, declined to hear petitioner's Commerce Clause argument, invoking the long-recognized California rule of appellate practice that arguments raised for the first time in a reply brief will not be entertained absent a showing, not made by petitioner, that its failure to timely present the issue before was justified. (Petition, Appendix B, pp. 14a-15a.) The California Supreme Court summarily denied review

also without deciding the Commerce Clause issue. (Petition, Appendix A, p. 1a.)

Thus, the Commerce Clause issue relative to the in-state office requirement was expressly not decided below. This means that a critical requirement for the exercise of this Court's jurisdiction under Rule 14.1(h), i.e., a final state court decision on the merits of the Commerce Clause issue, is missing. By not timely raising it before the California courts, petitioner is deemed to have waived its right to raise the Commerce Clause issue before this Court. *Bailey v. Anderson*, 326 U.S. 203, 206-207 (1945); *Herndon v. Georgia*, 295 U.S. 441, 443 (1935). There being no basis for this Court to take jurisdiction over that issue, the petition must be denied as to petitioner's Question No. 1.[3]

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[3] However, any decision by this Court first to grant review and then to strike down the in-state office requirement as unconstitutional would not lead to a different result herein since it is undisputed that petitioner has not complied with any of the operational and disclosure requirements provided in the 1990 legislation.

As set forth in more detail above, Welfare & Institutions section 14125 et seq. established a set of new operational and disclosure requirements for suppliers of incontinence supplies of which the in-state office requirement is only one. Petitioner has never contended that any of these other requirements violates the Commerce Clause. That petitioner has not complied with any of these requirements is not subject to dispute, given its contention that it is not subject to California's regulatory authority and is completely exempt from complying with any Medi-Cal regulations. (See Argument section II, *infra*.) Since the decision below correctly held that the state's regulations were lawful, the department's refusal to activate petitioner's Medi-Cal provider number, so long as the latter refuses to comply

The same result ensues regarding the Medicare Part B reimbursement issue. (Petition, p. i.) Although petitioner did timely raise that issue before the California Court of Appeal, that court expressly declined to reach it in view of the fact it affirmed the trial court's ruling on other grounds, i.e., that as a provider of incontinence supplies to Medi-Cal program beneficiaries, petitioner was fully subject to California's regulatory authority, and its failure and refusal to comply with the state-established minimum qualifications for providers of incontinence supplies authorized the department to deactivate petitioner's provider number. (Petition, Appendix B, pp. 11a-13a.) There is, therefore, no final state court ruling on the reimbursement issue either. In these circumstances, the petition must be dismissed in its entirety since there is no basis for this Court to hear Question No. 2 either. *Whitney*, 274 U.S. at 360.

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with any of them, (not just the in-state office requirement), is proper. Thus, the department would still have a lawful basis upon which to continue to deny petitioner a Medi-Cal provider number, without regard to how the issue of the constitutionality of the in-state requirement is ultimately resolved. Consideration of that question, in the circumstances presented herein, would amount to nothing more than an academic exercise since the ultimate result would be unaffected. The department would still prevail. This is yet another reason the decision below was correct and why review by this Court is not warranted.

II.

ASSUMING THE ISSUE OF CALIFORNIA'S AUTHORITY TO REGULATE THE CONDITIONS UNDER WHICH PETITIONER WILL BE PERMITTED TO BECOME A MEDI-CAL PROVIDER IS PROPERLY BEFORE THIS COURT, THE DECISION BELOW WAS PROPER SINCE PETITIONER IS SUBJECT TO CALIFORNIA'S REGULATORY AUTHORITY, AND IT IS UNDISPUTED THAT PETITIONER HAS FAILED AND REFUSED TO COMPLY WITH ANY OF THE STATE'S REGULATIONS

The only federal question that is arguably properly before this Court is whether federal Medicaid law authorizes the State of California to establish minimum standards that prospective providers of incontinence supplies must satisfy in order to participate in the program.[4] The answer to this question is clearly "yes."

It is well settled that, under Medicaid, states enjoy a considerable amount of discretion in determining the amount and scope of the services they will provide and/or pay for. *Schweiker*, 457 U.S. at 589-91. Also not subject

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[4] As noted, this issue is not directly raised in the petition. This Court could, therefore, completely ignore it and dismiss the petition on the basis of the arguments presented in the preceding section regarding the issues that are squarely raised by the petition. Nonetheless, it is arguable that the issue of the nature and extent of the state's regulatory authority under Medicaid is indeed before this Court since it formed the basis of the decision below, it does involve a federal question, and the issue is addressed, if only briefly, in the petition. For these reasons, respondent will proceed to discuss this issue in this section. (See Supreme Court Rule 14.1(a); see also *Blum v. Bacon*, 457 U.S. 132, 137 n. 5 (1982) ("respondent may rely on any matter appearing in the record in support of the judgment below."))

to dispute is the fact that, with regard to Medicaid provider qualifications, federal law not only authorizes states to establish minimum standards for the participation of these entities in their respective programs, it *requires* states to establish such criteria in order to obtain approval of the state plan by the federal Medicaid agency. See also 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A). Thus, the California Court of Appeal correctly concluded that the department was clearly authorized to establish the requirements set forth in Welfare and Institutions Code section 14125 et seq. governing providers of incontinence supplies and that, given petitioner's failure to comply with these regulations, the deactivation of its Medi-Cal provider number was proper. (Petition, Appendix B, pp. 12a-13a.)

Petitioner argues that it need not comply with these regulations. It states that while it is not contending that California may not "exert proper supervision" over suppliers to the Medi-Cal program, it does not "wish" to be such a supplier, "wishing" instead "to continue to provide [supplies] only to Medicare [beneficiaries] and to have DHS fulfil (sic) its separate obligation to make copayments on behalf of appropriate patients." (Petition, p. 9.) This is a modified version of petitioner's primary arguments below, namely, that because the Medicare Part B beneficiaries it supplies are Medicare, rather than Medi-Cal, beneficiaries, petitioner is beyond the reach of California's regulatory authority, notwithstanding the fact it seeks Medi-Cal reimbursement for products used by these same beneficiaries. The bottom line, as the Court of

Appeal correctly put it, is that petitioner believes California should simply pay, "no questions asked." (Petition, Appendix B, p. 11a.)

The appellate court, however, correctly rejected petitioner's contentions in this regard. Citing *Samuel v. California Department of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), the Court of Appeal noted that Medicare Part B coverage is included in a recipient's Medi-Cal benefits package[5] and agreed with the department's contention that this inclusion means that these crossover beneficiaries must be considered Medi-Cal patients whose care is subject to California's laws and regulations. (Petition, Appendix B, p. 5a; see *Samuel* 570 F. Supp. at p. 573.) The court below further stated that the state plan, specifically approved by the federal Department of Health and Human Services, explicitly provides for state regulation

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[5] It bears noting that the only reason why Medicare is implicated in this action is because Medi-Cal regulations require that its program beneficiaries apply for Medicare benefits as well if they qualify. Tit. 22, Cal. Code Regs. § 50777; (see Appendix B hereto). The fact that once enrolled in Medicare, California pays the Part B premium and co-payments on behalf of these individuals in no way diminishes their status as Medi-Cal beneficiaries. These crossover beneficiaries enter the system as Medi-Cal beneficiaries and remain as such throughout. *Samuel*, 570 F. Supp. at 573. Medi-Cal's requirement that these persons enroll in Medicare is simply a method through which the state is able to shift some of the cost of the services provided to the federal government. It should be noted further that section 50773 of title 22 of the California Code of Regulations (see Appendix C hereto), explicitly provides that these premium payments under the "buy-in" agreement are made on behalf of *Medi-Cal* beneficiaries.

of entities providing services to Medicare Part B beneficiaries. (Petition, Appendix B, p. 12a; see also 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A) which, inter alia, require the states to establish minimum standards relating to the quality of services and standards of care for Medicaid beneficiaries.)

In upholding the trial court's conclusion that petitioner was subject to California's regulations, the California Court of Appeal correctly viewed it as almost inconceivable that the state would be required to reimburse providers such as petitioner while at the same time being precluded from having any say over the qualifications of these providers or the products and services these entities provide. The court stated:

> "Medicare and Medicaid are designed to coexist. Common sense dictates that government must take responsibility for funds it expends on social programs." (Petition, Appendix B, p. 12a.)

Thus, petitioner's "wishes" with regard to its provider status and its apparent "concession" that California may "supervise," but presumably not "regulate," its participation in the Medi-Cal program are irrelevant and entirely beside the point.[6] State and federal law make it abundantly clear that petitioner is a Medi-Cal provider and that it is fully subject to this state's regulatory authority. As the Court of Appeal concluded:

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[6] Petitioner never explains what it means by its use of the term "supervision" in this context. Nor does it cite any authority for the peculiar proposition that states may "supervise," but not regulate, providers of services to cross-over beneficiaries.

> "Del Crane is a provider of incontinence medical supplies seeking to receive payments from Medi-Cal fund, and California has regulations . . . concerning such providers. Del Crane's contention there was no authority for the state to deactivate the Medi-Cal provider number is without merit." (Petition, Appendix B, p. 13a.)

As it did below, petitioner again cites *New York City Health and Hospitals Corporation v. Perales*, 954 F. 2d 854 (2nd Cir. 1992) in support of its contention that crossover beneficiaries are Medicare beneficiaries. (Petition, p. 7.) Petitioner also cites *Perales* for the proposition that states are required to reimburse providers the full 20% of the cost of the products or services they provide which is not paid by Medicare under Part B. However, as noted above, and as the Court of Appeal found, the specific amount petitioner is owed by Medi-Cal is not the issue in this proceeding. The question here is simply whether petitioner must comply with Medi-Cal's regulations. *Perales* is of no help to petitioner in this regard since the state of New York's authority to regulate the provider involved in that case was not addressed by the Second Circuit because it was not at issue. (See Petition, Appendix B, p. 11a.) Thus, petitioner's reliance on *Perales* is misplaced.[7] Moreover, the court below noted that a different federal court, the dissenting justice in *Perales*, as well as the

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[7] Also beside the point and irrelevant for these same reasons is petitioner's argument that subsequent legislation has allegedly superseded the conclusions regarding the reimbursement issue reached by the court in *Samuel*. (Petition, pp. 9-10.)

federal Medicaid Agency have all concluded that cross-over beneficiaries are Medicaid beneficiaries. (Petition, Appendix B, pages 9a-11a.)

Thus, petitioner's argument that the holding below must yield to contrary (and higher) federal authority under the Supremacy Clause of the United States Constitution (petition, p. 10) is without merit. The Supremacy Clause to the United States Constitution is not implicated here. As both the trial court and the Court of Appeal noted, petitioner failed to establish that California Welfare and Institutions Code section 14125 et seq. violate any state or federal law. (Petition, Appendix B, p. 12a.) To the contrary, the decision below is fully consistent with the Medicaid scheme established by Congress, which, as noted, clearly authorizes states to regulate providers.

CONCLUSION

The decision below did not reach either of the questions presented for resolution in the instant petition. There being no final state court judgment or decision regarding the merits of either question, the petition must be denied under Rule 14.1(h). To the extent the issue of the State of California's authority to establish and enforce minimum participation standards for providers of services to Medi-Cal beneficiaries is properly before this Court, the decision below upholding such authority was based on well-settled law regarding the powers delegated by Congress to the states under the Medicaid statutory scheme. Since it is fully consistent with federal law in this

regard, no scrutiny of the decision below by this Court is warranted.

For these reasons, the petition should be denied.

Dated: February 21, 1995

Respectfully submitted,

DANIEL E. LUNGREN
Attorney General of the
State of California

CHARLTON HOLLAND
Assistant Attorney General

DENNIS ECKHART
Supervising Deputy Attorney
General

*RAOUL THORBOURNE
Deputy Attorney General
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone (916) 324-2884

Attorneys for Respondent

*Counsel of Record

APPENDIX A

California Welfare and Institutions Code
Section 14125 et seq.

Article 3.7

INCONTINENCE MEDICAL SUPPLIES

§ 14125. Purpose of article; reimbursement

The purpose of this article is to establish provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program. Reimbursement for incontinence medical supplies shall consist of the weighted average of the negotiated contract prices within each product category * * * , plus a markup fee equal to 40 percent of the resulting adjusted contract price.

§ 14125.1 Definitions

Unless the context requires otherwise, the definitions set forth in this section shall govern the construction and meaning of the terms and phrases used in this article.

(a) "Incontinence medical supplies" means disposable medical supplies that are covered benefits under the Medi-Cal program pursuant to subdivision (s) of Section 14132 when prescribed by a physician for the treatment of individuals who are incontinent. Incontinence medical supplies include, but are not limited to disposable diapers, briefs, underpads, undergarments, liners or pads, pant and pad systems, and skin care products.

(b) "Department" means the State Department of Health Services.

* * *

(c) "Manufacturer" means any person, partnership, or corporation who assembles or combines the components of incontinence supplies into a final product sold to dealers.

(d) "Principal labeler" means any person, partnership, or corporation who purchases from a manufacturer an assembled product which is sold to dealers under the principal labeler's label.

(e) "Dealer" means any person, partnership, corporation, or other entity that is recognized by the manufacturer or principal labeler as a provider or retail outlet for its line of incontinence medical supplies, and which provide these supplies directly to consumers. The term "dealer" includes a retailer.

§ 14125.2 Product and provider qualification; "product" and "general retail distribution" defined

(a)(1) To qualify for Medi-Cal coverage a product shall be in general distribution, sold to the general public, and comply with any standards for products established by law or regulation. No product that is manufactured, distributed, or otherwise promoted for the exclusive use of beneficiaries of the Medi-Cal program shall be a Medi-Cal benefit.

(2) For the purposes of this section, "product" means any product which is in general retail distribution.

(3) For purposes of this subdivision, "general retail distribution" means either of the following:

(A) The product is included in a listing of approved products for purchase either by the federal or state government.

(B) The product is on display and available for purchase by customers for private payment at retail outlets which are open to the general public.

(b) In order to qualify as a Medi-Cal provider of incontinence medical supplies, a dealer shall have an established place of business that is readily identifiable as a medical supply business, be open to the general public at regularly established business hours, have incontinence supplies in stock on the premises or in a warehouse under the provider's direct control, and meet all local laws and ordinances regarding business licensing and operations. The department shall establish additional rules and regulations for participation in the Medi-Cal program as it deems necessary to ensure adequate safeguards to the integrity of the Medi-Cal program.

§ 14125.3 Contract prices; reduction of weighted average of negotiated prices; premium underpads; other products

The department shall reduce the weighted average of the negotiated contract prices within each product category in effect on June 30, 1992, as follows:

(a) For all premium underpads, as defined by the department, by 24 percent.

(b) For all other incontinence medical supply products, as defined by the department, by 14 percent.

§ 14125.4. Utilization controls; expenditure limits for incontinence medical supplies; amount; adjustment; exemptions

(a) No later than January 1, 1994, the department shall establish utilization controls that limit expenditures for incontinence medical supplies per beneficiary to no more than one hundred sixty-five dollars ($165) per month. Incontinence creams and washes shall be excluded from this limitation. The expenditure limit established by this section may be adjusted in the annual Budget Act to reflect changes in wholesale prices. These utilization controls shall be published in provider bulletins.

(b) The department shall, by prior authorization, allow a beneficiary to exceed the utilization limits established by this section when justified to the department's satisfaction not later than January 1, 1994.

(c) Notwithstanding any other provision of law, no regulations shall be necessary to define the incontinence medical supplies subject to the reductions required in Section 14125.3, or to establish and implement the utilization controls required in this section.

* * *

§ 14125.8. Provider disclosures; claim submission; provider number issuance moratorium

(a) In order to more fully identify the owner or owners of companies or corporations that apply to be or currently are providers of incontinence medical supplies,

within 30 days of the receipt of a request from the department, or a request to the department from the Department of Justice, the applicant or provider shall provide, as part of the application process or as a condition of continued participation in the Medi-Cal program, the following:

(1) The name of the corporation, the official titles of the applicants, and a list of all the corporate officers.

(2) The California driver's license or California identification card number of the applicants, coowners, corporate officers, and financially interest parties.

(3) The applicant's business permit control number, issued by the State Board of Equalization, for the business location where services are rendered to the public.

(4) A statement of all current sources of capital, identity of all investors, disclosure of all manufacturers, suppliers, and providers currently doing business with the applicant, and disclosure of all entities to whom the applicant has extended a line of credit.

(5) A statement certifying that all information supplied pursuant to this section is accurate.

(b) A Medi-Cal provider of incontinence supplies shall not submit a claim for goods or services to the department prior to the date the goods or services are delivered to the Medi-Cal beneficiary. The date of delivery to a beneficiary shall be the earlier of the date the beneficiary actually received the goods or services, or the date the goods were posted or otherwise dispatched from the provider's premises and control. A claim submitted to the department prior to the date of delivery shall not be

paid. Violation of this subdivision shall be grounds for expulsion from the Medi-Cal program.

(c) The department may implement a 180-day moratorium on the issuance of new provider numbers for incontinence medical supply dealers when the department determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

§ 14125.9. Incontinence supplies contracts pursuant to § 14105.3

Nothing in this section shall be interpreted as limiting or interfering in any way with the department's authority to contract for the provision of incontinence medical supplies pursuant to subdivision (b) of Section 14105.3.

APPENDIX B

Title 22, California Code of Regulations Section 50777

§ 50777. Requirement to Apply for Medicare.

(a) The following Medi-Cal applicants and beneficiaries shall be required to apply for Medicare Part A:

(1) Any person 64 years and 9 months of age or older.

(2) Persons applying for Medi-Cal on the basis of blindness or disability.

(3) Persons who are receiving disability payments under title II of the Social Security Act or Railroad Retirement program unless the county can obtain verification of receipt of Social Security title II disability payments in accordance with section 50167. In these instances Medicare enrollment is deemed to be automatic beginning with the 25th month of receipt of this benefit and application is not required.

(4) Persons receiving dialysis-related health care services.

(b) The following Medi-Cal applicants and beneficiaries shall be required to apply for Medicare Part B:

(1) Persons who are applying for Medi-Cal on the basis of being aged.

(2) Persons applying for Medi-Cal on the basis of blindness or disability unless the county can obtain verification of receipt of Social Security Title II disability payments in accordance with section 5167 [sic]. In these instances Medicare enrollment is deemed to be automatic beginning with the 25th month of receipt of this benefit and application is not required.

(3) persons receiving dialysis-related health care services, unless the county can obtain verification of receipt of Medicare Part A benefits in accordance with section 50167. In these instances, Medicare Part B enrollment is deemed to be automatic and application is not required.

(c) The persons specified in (a) and (b) shall submit verification to the county department of the approval or denial of their Medicare eligibility within 60 days of the day they are notified or the requirement to apply or within 10 days of the notification of approval or denial if their eligibility for Medicare is not determined within 60 days. Except for those persons applying under Sections 50258 and 50256, persons who would only be eligible for Medicare Part A if they paid a premium shall not be required to accept Part A benefits.

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APPENDIX C

Title 22, California Code of Regulations Section 50773

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§ 50773. Medicare Buy-In.

(a) Medicare Buy-In is the payment of Medicare Part B premiums by the Department under the California Medicare Buy-In agreement with the Social Security Administration for Medi-Cal beneficiaries who are:

(1) Eligible under the SSI/SSP. Other PA or MN program on the basis of age.

(2) Eligible under the SSI/SSP, Other PA or MN program on the basis of blindness or disability and also eligible for Medicare Part B in accordance with section 50775(a).

(b) State payment of Part B premiums under the Buy-In provisions shall become effective the:

(1) Second month after the month in which Medi-Cal eligibility is approved for MN persons who were not eligible for a federally covered Medi-Cal program in the month before their first month of MN eligibility.

(2) First month of eligibility for PA and Other PA recipients and MN persons not specified in (1).

(3) The first month after the month of eligibility for qualified Medicare beneficiaries in accordance with Section 50258.

(4) The first month eligibility is approved for Specified Low-Income.